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MEDICAL SERVICE

PSYCHIATRY IN MILITARY LAW

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DEPARTMENTS OF THE AIR FORCE, THE ARMY, AND THE NAVY
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Medical Service

PSYCHIATRY IN MILITARY LAW

This manual will serve to acquaint medical officers with the problems concerning military psychiatry and with the rules and legal standards applicable to the military jurisdiction.

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Chapter 1

INTRODUCTION

1–1. General Information:

a. This manual presents and explains the legal standards applied in military law to determine whether a person was mentally responsible, at the time of an alleged offense, and has the requisite mental capacity to be tried by court-martial. Because a diagnosis of a particular psychiatric disorder, viewed in the light of these legal standards, may result in a conclusion that the individual is or is not criminally accountable, certain psychiatric disorders are discussed with reference to their general legal effect. Important aspects of psychiatric medicolegal examinations are discussed and methods, procedures, and standards are suggested therefor. Certain matters pertaining to psychiatric testimony before courts-martial with which the physician should be acquainted are mentioned. So that he may properly perform his duties as psychiatric examiner and prospective expert witness before a court-martial, the medical officer should become thoroughly familiar with the legal concepts of mental responsibility and capacity. This manual does not constitute legal authority nor may it be cited as such.

b. While it is obvious that the established principles of law are binding upon all persons to whom they apply, it must be clearly understood by the reader that the discussions relating to psychiatric tenets and opinions are not binding upon anyone. Such matters are furnished for information and guidance only. They will not be used to influence or in any way control the independent judgment of counsel, psychiatrists, witnesses (lay or expert), or anyone else in making personal conclusions, arriving at opinions and diagnoses, or giving testimony affecting mental responsibility, capacity or accountability.

c. The Manual for Courts-Martial, United States (referred to herein as MCM), as modified by published decisions of the Court of Military Appeals establishes these concepts. In a given case, where there is a substantial question as to the law, the medical officer can and should obtain a complete statement of the law from his staff judge advocate or legal officer.

1–2. Use of Report of Board of Medical Officers and Psychiatric Evidence:

a. When a person subject to military law is accused of an offense, a board of one or more medical officers may be convened to examine the accused and to submit a written report on his mental condition as it relates to the offense charged and to his ability to stand trial. This report may be requested before, during, or after trial by court-martial. The importance of such a report, adequately prepared, cannot be overemphasized, but it is equally important to understand that the report itself is not generally admissible in evidence. However, outside this evidentiary limitation, it serves many essential functions. For example, the report:

(1) Assists commanders, judge advocates, legal officers and convening authorities in determining the proper disposition of charges;

(2) Assists counsel in determining whether a question of mental capacity will be raised at the trial, and if so, provides a basis upon which the counsel may interrogate medical officers prior to and during trial;

(3) Assists reviewing authorities in determining first, legal sufficiency, second, whether clemency should be extended, and third, whether an accused possesses restorable potential.

b. *In military justice the legal determination of sanity and lesser degrees of mental impairment is primarily a question of fact that can only be resolved by members of a court-martial.* The legal determination is not made by psychiatrists, medical authorities, counsel, expert or lay witnesses. Such personnel can only provide evidence (personal opinions included) from which the court-martial must resolve the issue. As previously noted, the medical or psychiatric report is normally not admissible before the court but it can serve as a useful guide for both the expert witnesses and counsel in the organization and orderly presentation of essential testimony on the issue of mental accountability. It can also reduce the amount of time required for experts in court. Therefore, it behooves all concerned with the issue of mental accountability to insure that the written report is adequate. It must be pointed out that mere conclusion, broad opinions, diagnoses, and labels attached to an accused's mental condition are frequently insufficient and can be misleading. These should be stated when appropriate. Of greater important is the medical officer's explanation of how an accused's condition did affect or may have affected his mental responsibility in regard to the offense charged or conduct questioned. Mere explanation of the underlying facts and background which prompted an accused to commit certain acts is often not very significant for court-martial purposes. The legal requirement is whether an accused had a mental defect, disease, or derangement which exculpates him from trial and punishment or negates the required state of mind for the particular act charged. A properly prepared report which discusses these issues can be of inestimable value to expert witnesses and counsel in preparing and presenting testimony, and to commanders and convening authorities who must decide whether to refer a case to trial. An adequate report will not only save time and effort, but insure appropriate disposition of charges. Since psychiatric reports are used by many non-medical persons connected with the administration of military justice, they should be prepared so as to be clearly understood by laymen. This manual is intended to aid in this objective.

c. It often happens that, shortly after the commission of an offense, an accused person is examined with respect to his psychiatric condition although a board of medical officers is not appointed. This type of examination confirms whether or not a psychiatric condition exists which affects or diminishes mental responsibility, constitutes mitigation, or is of no significance. It is important because it advises counsel, commanders, and convening authorities of pertinent factors and may make it unnecessary to appoint a board. A board is warranted only when the report or other evidence indicates a reasonable basis for the belief that criminal accountability may be affected or in issue. Since the result of this examination may be of considerable value to a medical board appointed at a later date, as well as to the other authorities mentioned, a careful record of such an examination always should be made. It should be incorporated in the patient's medical history file, and a copy thereof transmitted to the patient's commanding officer. Every psychiatric report pertaining to a patient's criminal accountability should follow generally the form described in paragraph 4–2.

Chapter 2

STANDARDS OF MENTAL RESPONSIBILITY AND CAPACITY UNDER MILITARY LAW

2–1. Military Standards:

a. A person is not mentally responsible in a criminal sense for an offense unless he was, at the time, so far free from mental defect, disease, or derangement as to be able concerning the particular act charged to distinguish right from wrong and to adhere to the right. He must be capable of forming any necessary specific intent or entertaining a required state of mind to be responsible for any offense of which such intent or state of mind is an essential element. In order to be tried, he must have sufficient mental capacity to understand the nature of the proceedings against him and intelligently conduct or cooperate in his defense. The phrase "mental defect, disease, or derangement" comprehends those irrational states of mind which are the result of deterioration, destruction, or malfunction of the mental, as distinguished from moral faculties. The standards of both mental responsibility and capacity are embodied in three questions found in the Manual for Courts-Martial and a fourth question suggested by decision of the Court of Military Appeals. Expert opinions and other evidence in answer to these questions permit the court-martial to apply the standards in fixing an accused's overall accountability which includes mental responsibility, partial mental responsibility, and mental capacity. The four basic questions are:

(1) Was the accused at the time of the alleged offense so far free from mental defect, disease, or derangement as to be able concerning the particular act charged to distinguish right from wrong?

(2) Was the accused at the time of the alleged offense so far free from mental defect, disease, or derangement as to be able concerning the particular act charged to adhere to the right?

(3) Does the accused possess sufficient mental capacity to understand the nature of the proceedings against him and to intelligently conduct or cooperate in his defense?

(4) Was the accused at the time of the alleged offense so far free from mental defect, disease, derangement, or any other mental impairment as to be able, concerning the particular acts charged, to form or entertain the specific intent or other mental state required?

b. *Mental Responsibility.* An analysis of this standard discloses that answers to the following fundamental questions pertaining to the mental condition of the accused at the time of the alleged offense will determine whether he is to be considered mentally responsible:

(1) Did the accused have a mental defect, disease, or derangement?

(2) If he did have a mental defect, disease, or derangement, did it render him unable to know that the particular act charged was wrong?

(3) If he did have a mental defect, disease, or derangement:

(a) Did it deprive him of the power of choice or volition so that he was unable, concerning the particular act charged, to adhere to the right; or,

(b) Did the defect, disease, or derangement, although not rendering him incapable of adhering to the right with respect to the act charged, tend to impair or diminish his ability to do so?

(4) If he did have a mental defect, disease, derangement, or other mental impairment, but was able concerning the particular act charged to distinguish right from wrong and adhere to the right:

(a) Did it deprive him of the mental ability to form any specific intent found in the act charged?

(b) If the act charged did not involve a specific intent but did involve a special frame of mind such as knowledge, willfulness, etc., was he incapable of entertaining any such frame of mind found therein?

2–2. Knowledge That the Act Was Wrong:

a. *Primary Test.* MCM lays down as the primary test of mental responsibility the ability to distinguish right from wrong, and to adhere to the right, with respect to the act charged. The medical officer must know two things about the word "wrong," as herein used:

(1) It is a concrete, not an abstract concept.

(2) It implies that the community (the military or society generally) considers the act wrong. The appraisal of the act within the accused's own private ethical system is not the standard. These are important elements in understanding the problem and should be clearly grasped by the medical officer.

b. *It is a Concrete, Not an Abstract Concept.* It is not true that the test of mental accountability is whether the accused knew right from wrong generally. Knowing the difference between right and wrong is an abstract, philosophical concept. The problem is—Did he know this particular act was wrong? How does the physician determine that? Such behavior as flight, attempt to conceal commission of the act, statements of repentance and voluntary surrender to civil or military authorities may be considered evidence suggesting that the accused knew he was doing something wrong. In most cases, the act is such that any non-psychotic person must know that the act is wrong. Usually, an individual with a character and behavior disorder, in committing an offense, knows he is doing wrong. That he may not care, or may seem unable to restrain himself, are different issues. But he normally knows that it is wrong to steal, perpetrate frauds, or commit assaults.

c. *Private Ethics Not an Issue.* Suppose an intelligent, well-educated enlisted man, charged with insubordination, gives the following explanation: "I am more intelligent than my officers, and it seems to me wrong that I should have to obey orders given by men who are my inferiors." Even though it be assumed that the accused honestly holds that belief, the medical officer should not testify that the defendant did not know that the act is wrong, because first, the accused's ethical belief is not the result of any mental defect, disease, or derangement; and second, the accused obviously knows that the military establishment considers the act wrong. It is considered "right" only in his own private ethics. On the other hand, suppose a paranoid schizophrenic has a delusion resulting from his mental disease that a person advancing toward him is about to kill him and, acting under the erroneous impression that it is necessary to take the person's life to preserve his own, kills the supposed attacker. In such a case, the accused does not know that the act is wrong (in fact, believes it is right) and is, therefore, not mentally responsible for the homicide.

2–3. The "Adhere to the Right" Doctrine:

a. If the accused knows that the act is wrong, yet cannot "adhere to the right" because of some mental defect, disease, or derangement, he is not mentally responsible. This concept recognizes that if a person because of mental defect, disease, or derangement, is deprived of the power of choice or of volition, he does not possess the freedom of action essential to criminal responsibility. This presents the medical officer squarely with the thesis of the "adhere to the right"

doctrine. It should be applied in any given case for cogent reasons only, and with great discretion, since it lends itself readily to abuse. Any accused can say that, when he committed the assault, theft, or murder, something made him do it, and that he could not restrain himself. The medical officer should view such claims with caution. The "adhere to the right" doctrine is not intended to apply to actions committed as a result of drunkenness, nor to the furies and frenzies of an ill-tempered man who is free of psychosis or psychoneurosis. It does not apply to acts which are the results of character or behavior disorders. The doctrine is seldom applicable, and will normally be limited to actions committed by persons with a mental disease and because of that mental disease. The medical officer should be skeptical of an alleged inability to adhere to the right that was, for the first time in the subject's life, suddenly generated just before the commission of the crime. Prudence indicates that before testifying that an accused did the act because of a psychoneurotic compulsion (as distinguished from that generated in a psychosis), the medical officer should be satisfied first, that the act is part of a repeated psychoneurotic pattern; second, that the accused exhibited mounting anxiety or tension which was relieved by the theft, arson (or whatever the act was); and third, that the compulsion generated by the illness was so strong that the accused was deprived of his ability to adhere to the right. It is generally believed that only very rarely do offenses committed within the framework of a denoted compulsive psychoneurosis satisfy all three criteria, particularly the third. *Nevertheless, the medical officer must make his own independent appraisal and conclusion in that regard.*

b. Such compulsions in psychotics usually come about in connection with commanding voices, persuasive visions, or overwhelming delusions which, by their nature (and within the frame of reference of the psychosis), compel the patient to commit the act.

c. The accused's ability to adhere to the right in the face of the prospect of immediate detection and apprehension is not the controlling consideration in determining whether he is mentally responsible within the doctrine. The question is: Did the mental defect, disease, or derangement deprive him of his ability to adhere to the right as to the offense charged under the actual conditions which prevailed at the time? This is the crux of the matter. The hypothetical effect of immediate detection and apprehension may be one of the factors considered by the medical officer in arriving at his opinion. It may also play a proper role in cross-examination. It cannot be made the subject of a governing instruction nor can it be used to limit the testimony of expert witnesses.

2–4. Nature or Quality of the Act. The medical officer may be asked by attorneys unfamiliar with the standards of military law whether the accused knew the nature or quality of his act. While this is one of the tests of criminal responsibility in many states, it is not a test applied by courts-martial. As a practical matter, the phrase "nature of the act" may be considered substantially the same as "wrongfulness" or "harmfulness."

2–5. Result of Lack of Mental Responsibility. A finding of the court, or other judicial determination that an accused is not guilty or cannot be found guilty because of lack of mental responsibility, does not automatically adjudge him to be insane nor does it necessarily constitute adequate reason for confinement to a mental hospital. Such a determination only indicates that a reasonable doubt exists concerning the accused's mental responsibility with respect to the offense in question. The medical disposition of such an individual should be determined by admission to a hospital for appropriate observation, treatment, and disposition in accordance with existing regulations.

2–6. Mental Capacity at Time of Trial and Result of Lack of Mental Capacity. In addition to the legal standard of mental responsibility at time of the alleged offense, another and a different legal standard is established to determine whether the mental condition of an accused at time of trial is such that he may be tried by court-martial. It must appear beyond a reasonable doubt that the accused possesses sufficient mental capacity to understand the nature of the proceedings against him and intelligently to conduct or cooperate in his defense. When an accused is considered mentally responsible at the time of the commission of the alleged offense, but at time of trial lacking in sufficient mental capacity to understand the nature of the proceedings against him and intelligently to conduct or cooperate in his defense, he may not be tried by court-martial. However, this does not amount to an acquittal. If the accused lacks such mental capacity, the court-martial proceedings may be held in abeyance until he regains sufficient mental capacity to stand trial, or the proceedings may be dismissed and appropriate administrative action taken.

2–7. Partial Mental Responsibility — Evaluation of Specific Intent and Premeditation:

a. Some offenses consist of an overt act plus intent, willfulness, or some other state of mind. An accused may have committed an overt act, yet have had a mental condition which deprived him of the ability to entertain the intent or state of mind required for the offense charged. For example, the crime of desertion consists of the act of absence without leave, plus the intent not to return (or the intent to shirk hazardous duty). In a given case, an accused charged with desertion might, because of some mental condition (not necessarily confined to psychosis or psychoneurosis) be incapable of forming the required intent. In such a case, the psychiatric testimony might lead the court to strike out the "intent" element of the charge, thus reducing the offense to absence without leave. Thus, the medical officer does not discharge his full duty when he reports on the sanity of the accused in general. He must be prepared to say whether the accused's mental state was such that he was capable of having the degree of intent, willfulness, premeditation or knowledge which the law requires for determination of guilt or for a certain degree of guilt. An inability to form the requisite state of mind with respect to the act charged will reduce any guilt involved to a lesser offense, if any, not requiring proof of that state of mind. Evidence of a mental condition from which a court-martial could reasonably find that the accused's mental ability was impaired, raises an issue of partial mental responsibility which requires that the court-martial be given appropriate instructions. For the court to hold an accused fully accountable under these circumstances, it must be convinced beyond a reasonable doubt that the accused's mental condition was not of such consequence and degree as to deprive him of the ability to entertain the particular state or frame of mind required for the commission of the offense charged.

b. There is still another field in which the expert can aid the interest of military justice. The evidence given by him may assist the court not only in its determination of guilt or innocence, but also in its function of imposing an appropriate sentence. If the court determines that the accused, with respect to the act charged, could distinguish right from wrong, and adhere to the right, and that he possessed the necessary state of mind, it will consider him mentally responsible for his conduct. On the other hand, the court in performing its function of imposing an appropriate sentence is, in most cases, given considerable latitude. For the purposes of punishment the law recognizes that the true measure of an accused's culpability may depend in part upon various extenuating and mitigating circumstances, including the

accused's mentality. Accordingly, a court-martial may properly consider in extenuation, evidence showing that the accused is suffering from some form of mental disorder. When such a condition exists, the defense counsel may produce evidence of its existence. This will depend on psychiatric testimony. The court, in turn, should consider such a mitigating circumstance and endeavor to impose a sentence which is just and suitable to the true degree of culpability.

c. Although the court-martial is initially responsible for the punishment imposed, the sentence may be reduced or mitigated by reviewing authorities. When requested, the medical officer is under a duty to advise such an authority concerning the extenuating circumstances of any mental disorder. He should also give his opinion concerning the ability of the accused to profit from experience, from punishment or from confinement, and the probability of the accused's being rehabilitated for useful service. On the other hand, the accused's antisocial tendencies may be so deeply entrenched and the outlook for rehabilitation so poor, that this condition may be considered an unfavorable factor rather than a favorable or mitigating one.

Chapter 3

APPLICATION OF STANDARD TO PSYCHIATRIC CONDITIONS

NOTE: Chapter 2 was devoted primarily to clarification of legal principle and doctrine. The following deals more with law as it may be applicable to medical conditions. Admittedly, the assessment of human behavior is an extremely complex and difficult task; yet, the proper wedding of medical and legal principle is necessary to assist the courts in reaching fair and equitable decisions when faced with behavior of alleged "deviant" nature. The psychoses usually do not present major problems to either the medical officer or the courts. The psychoses constitute within the framework presented in this dissertation the "true insanities." Therefore, these are, in the greatest majority of cases, not held accountable. If one conceives of psychotic processes, be they organic or functional, as a disintegration of personality and ability to test reality, it should offer the medical officer little problem in relating this to the rule set forth by the military.

3–1. Problems Arising From the Use of Alcohol:

a. Alcoholic intoxication is not ordinarily a defense to a crime committed while drunk. If the accused has a chronic psychosis due to alcohol, or if there is evidence of marked organic cerebral deterioration due to alcohol, this may bring the condition within the classification of those mental disabilities which constitute a valid basis for a finding of lack of responsibility. In other words, psychoses due to alcohol, including delirum tremens, are generally considered "insanities" within the meaning of the law, but drunkenness is not.

b. While voluntary drunkenness is not a complete defense, it may be advanced by the defense for one or two purposes—to remove one of the elements of the crime, for example, specific intent, actual knowledge, or premeditation, reducing it to a lesser offense; or to affect the sentence in the eyes of the court or reviewing authority. If an individual is involved in a drunken brawl and badly injures another person, he might be charged with assault with intent to commit murder or voluntary manslaughter. The medical officer might find that he was so befuddled by liquor that he could not form a specific intent to do anything. If this is so, and if the court accepts it, the result would be to reduce the offense to simple assault or assault and battery. The primary question where drunkenness is concerned is usually whether an accused was so drunk that he could not entertain the requisite intent, knowledge, or special state of mind.

c. While drunkenness may deprive the accused of this capacity to form a specific intent, it does not necessarily do so. This is something to be determined by the facts in each case. The medical officer should weigh this possibility in each instance. This is especially true if exaggeration or feigning is suspected.

d. Difficult questions are raised as a result of crimes committed during periods of "pathologic intoxication" not amounting to insanity. Here the patient has a complete and genuine amnesia for the period, and may never, as long as he lives, remember the offense charged. Yet, within the framework of his intoxication, he may act rationally. For example, he may show premeditation, planning, and an effort to escape. In such cases, all the medical officer can do is to apprise the court of these facts, outline the nature of "pathologic intoxication," evaluate its effect upon mental responsibility, and explain that the amnesia is genuine, if such be the case.

e. In delirium tremens, the patient normally is in no condition to deliberate, form specific intent or special frame of mind, evaluate his acts, or adhere to the right.

f. For forensic purposes, voluntary alcoholic intoxication not amounting to a psychosis is a defect of character, will power, or behavior which is distinguished from mental defect, disease, or derangement. Its effect should be weighed against partial mental responsiblity (see paragraph 2–7). The intoxicated individual usually knows he is doing something wrong, even though at the moment he may not care.

3–2. Mental Deficiency:

a. The term "mental deficiency" may refer to a constitutional incapacity or be the result of deterioration or illness. The intelligence of the accused should be carefully assessed when indicated. If an individual is mentally defiicient to a marked degree, he may have more difficulty in lucidly comprehending social and military codes than does an average person. It may also be more difficult for him to form an intent or special frame of mind or "adhere to the right." This does not absolve the individual of responsibility for his acts (see paragraph 2–7). It may be reported to the court or reviewing authority as data which might be considered in mitigation of the offense and in fixing an appropriate sentence.

b. Extreme grades of mental deficiency may render the accused not responsible in the same sense as the psychotic, that is, unable concerning the particular act charged to distinguish right from wrong, to adhere to the right, or possess required mental state. In practice, such extreme grades of mental deficency seldom are encountered in the military. In the rare instances in which they are, their grossly inadequate comprehension and performance ordinarily lead to prompt separation.

c. It is better to report intelligence level in terms of mental age rather than as intelligence quotients (IQ). It is difficult to interpret an IQ to a court. But to say that the individual concerned has a degree of intellectual development equivalent to that of an average 8-year-old boy is a vivid and understandable way of picturing the defendant's intelligence. On the other hand, it is not to be assumed that an adult with a mental age of 8 must be judged by the same standards as a normal 8-year-old boy. A man of 23 with a mental age of 8 usually is much more shrewd, sophisticated, and has more wordly experience than a normal 8-year-old (see chapter 5).

d. Appraisal of intelligence on the basis of personal appearance and the answers to general questions of no recognized scientific validity are extremely unreliable. Accurate information about the individual's school, work, and personal life adjustment, as well as intelligence level, must be given careful consideration in making final evaluation of his ability to distinguish right from wrong, to adhere to the right, and to possess required mental state.

e. In order to reach an opinion where mental deficiency is an issue, one must take into consideration the individual's social background and the crime with which he is charged and its required mental state. For example, it is conceivable that an extremely feeble-minded youth from a benighted social environment might not have sufficient powers of discernment to know that petty thievery or sex perversion is wrong, but would be well aware that murder and arson are wrong and possess the required mental states.

3–3. Amnesia and States of Altered Consciousness:

a. *General Information.* Many times an accused tells the medical officer: "I don't remember anything. Maybe I did it, maybe I didn't. I just don't recollect." Or, he may assert that everything went blank and he does not know what happened next. Amnesia is one of the disorders of memory and is part of larger syndromes and is not a disease in itself. Perhaps the "antisocial" behavior of the accused is so at variance with his usual personality that the defense or the

accused alleges a sort of "double personality." The examiner in such cases is confronted with two responsibilities. First, he must determine the clinical explanation for the alleged amnesia; second, he must appraise the accused's criminal accountability (paragraphs 2–1 thru 2–7).

b. *Possible Clinical Explanations.* In the clinical explanations for periods of alleged amnesia, the following should be considered:

(1) Dissociative Reaction (Hysteria);
(2) Psychosis;
(3) Alcoholism and Drugs;
(4) Head Injury;
(5) Epileptic Fugue;
(6) Malingering; and,
(7) Acute and Chronic Brain Syndrome (Metabolic Disease States, Hypoxic Conditions, Toxic Agents).

c. *Dissociative Reaction (Hysteria).* In a genuine case, the individual will usually have had evidence of a neurotic disturbance and previous episodes of varying degrees of dissociative behavior (depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc.). A person who never had a dissociative reaction or fugue state until he committed a crime is highly suspect, since in most such cases the criminal act precipitated rather than followed the fugue (if indeed it be true fugue rather than malingering). A diagnosis of dissociative reaction should not be based solely on the alleged amnesia which covers the period of the crime. *The law is generally settled that an accused who experiences amnesia based on a dissociative reaction after the commission of an offense is not relieved from criminal responsibility nor is he unable to stand trial simply because he cannot recall the facts surrounding the offense or antedating its occurrence.* This would tend to address itself to whether an accused possesses sufficient mental capacity to understand the proceedings against him and to cooperate in his own defense. *A diagnosis of dissociative reaction should be based on sound clinical judgment, taking into consideration the general life pattern of the individual.*

d. *Psychosis.* Psychosis is recognized by the usual clinical criteria. The brutality or senselessness of a crime should not, by itself, be taken as proof of a psychosis. Defense counsel sometimes takes the position that "no sane man would have done a thing like this"—a doctrine which the psychiatric examiner cannot accept, for it is tantamount to saying that anyone can get away with murder by making it brutal enough. If a psychosis is established, for it to be related to this type of crime, it would likely be one in which fugue states or amnesic episodes frequently occur (schizophrenic psychoses, senile dementias, etc.) and not one in which these states are rare (true paranoia, psychotic depressions, etc.).

e. *Alcoholism.* Some persons habitually develop amnesia for their behavior while drunk. On the morning after, it is not uncommon for the celebrant to ask if he behaved badly the previous night. While varying degrees of amnesia may be a symptom found in alcoholism, it does not exculpate the accused (paragraph 3–1). There are special problems related to pathologic intoxication (paragraph 3–1d).

f. *Head Injury.* When one person assaults another, the medical officer's attention is likely to be focused on the injury received by the victim. He may forget that the assailant could have been injured also. If the assailant suffered a concussion, it is possible that he developed a retrograde amnesia so that when he subsequently insists that he does not recall the fray, he may be telling the truth. Since, however, in this case the assault occurs during a normal mental state, and the amnesia which later blots out memory of the assault results from injury incurred during the assault, the disordered mental state characterized by amnesia does

not exculpate the assailant. For this reason, witnesses to the assault should be questioned closely as to what happened to the assailant as well as to what happened to the victim. An electroencephalogram, a skull X-ray, and a careful neurologic examination may be indicated where the accused alleges a total amnesia for his act.

g. *Epileptic Fugue.* A person might not be legally responsible for an act committed under the impetus of an epileptic seizure. However, an underlying epileptic condition does not at all signify that an accused committed a particular offense during a moment when reason was dethroned by epilepsy. Epileptic fugue states, with automatic behavior and subsequent amnesia, may occur during a postictal (post-convulsive) period or may be the result of temporal lobe epilepsy ("psychomotor epilepsy"). The medical officer should be suspicious of a trance state or "epileptic fugue" alleged by the accused but never noted before the offense. These states do not usually have their onset in adult life. To support such an allegation, there should, in most cases, be a history of epilepsy in some form antedating the offense. An electroencephalogram, including a sleep record and other appropriate activating procedures as well as neurological evaluation, may be required. It should be borne in mind that the establishment of a diagnosis of convulsive disorder does not itself establish that the offense was committed during an epileptic fugue.

h. *Appraisals of Accountability for Amnesia Episodes.* The defendant's accountability is judged, within the framework of his amnesia, by the general formula in paragraphs 2–6 and 2–7. While the evaluation of accountability during periods of amnesia is difficult, the courts for the most part have accepted positions as exemplified by the two examples below:

(1) Suppose a sergeant frequently exhibited aggressive or suicidal reactions after consuming small quantities of liquor. He always had a genuine, total amnesia for these incidents. In one such period he attempted to rape a girl. When she screamed, he jumped over the fence and, by a circuitous route, eluded his pursuers, reached the post and went to his quarters. When awakened by the authorities, he seemed genuinely puzzled by the charges. He insisted he had been at a noncommissioned officers' meeting on the night in question, and with great indignation called on the first sergeant to prove his alibi. The truth was, that the meeting had been two nights before, but his memory for the evening of the offense had been completely wiped out. Through the entire trial he continued to insist that he could not have been in the girl's backyard because he had been at a meeting at the post ten miles away. In this case, the court probably would find him mentally responsible for his crime because, within the framework of his intoxication, he acted as if he were conscious of having done something wrong. He fled when the girl screamed; he ingeniously eluded pursuit. Thus the amnesia, by itself, is no evidence that he did not realize he was doing something wrong, and the fact that he abandoned his attempt when confronted with opposition suggests that he could "adhere to the right."

(2) By contrast, consider this hypothetical situation—During the middle of the night, an airman in a barracks got up and noisily proceeded to a clothes rack. As he walked, he jostled a number of cots, waking their occupants. He inserted his hand into the pocket of another man's trousers. Several of his barrackmates, by now fully aroused, intercepted him and brought him to the officer of the day. The accused seemed confused and denied any knowledge of the incident. Further inquiry disclosed somnambulism in childhood, and an electroencephalographic record was characteristic of psychomotor epilepsy. In this case, the indications are that the somnambulistic personality had no consciousness of doing anything wrong. He made no effort to walk silently or to move furtively. He apparently did not realize that

what he was doing (within the framework of his somnambulism) was something wrong. This was because of a mental disorder (psychomotor epilepsy). Accordingly, he probably should be found not mentally responsible.

When faced with a claim of amnesia, the medical officer should consider, one by one, the seven possibilities enumerated in paragraph 3–3b, and then make a clinical diagnosis. He then should consider accountability within that diagnosis. The formula already presented should be helpful.

i. *Acute and Chronic Brain Syndromes.* The brain syndromes which lead to disintegration of ego function and reality testing in many instances have degrees of altered consciousness, from mild confusion to coma, from circumscribed spotty memory difficulties to complete amnesia for events during an acute episode. There are various conditions which may cause acute and chronic brain syndromes, such as trauma, metabolic disease states, hypoxic conditions, toxic agents (industrial poisons, fumes, gases), and drugs.

3–4. Character and Behavior Disorders (Personality):

a. Character and behavior disorders impair the accused's criminal accountability only when they are of such nature and severity that they may have destroyed the accused's capacity to entertain a specific intent or form a particular and essential state of mind. These disorders are known variously as pathologic personality, constitutional psychopathy, psychopathic personality, and by several other names and under numerous subtypes. This is the kind of condition which is generally considered a "defect of character, will power, or behavior."

b. If the accused exhibits a character or behavior disorder, the medical officer must anticipate possible cross-examination by the defense counsel on this point. The counsel may ask such questions as—"Doesn't the very word 'psychopath' mean disease of the mind?" or "Would you say that a psychopath is a man of normal mentality?" or "Isn't psychopathy a mental disorder?" or "Can the psychopath really adhere to the right?" While it is not the medical officer's function to quote the law to counsel, it may give him some reassurance to know that *the mental accountability clauses of MCM, specifically exclude character and behavior disorders.* Their effects are limited to questions of specific intent and special mental state. *"Moral insanity," "emotional insanity," and "morbid propensity," so-called, constitute no defense before a court-martial and do not affect the criminal accountability of the accused.*

c. In appraising an individual with a character or behavior disorder the medical officer should bear in mind certain considerations. The disorder here is one of "moral" rather than "mental" faculties. There is ample evidence that individuals with character and behavior disorders know that their actions are wrong. Typically they seek to explain, neutralize, or escape from their offenses by evasive explanations, flight, or the piling up of one prevarication on another. These actions indicate that they know they have done something wrong. When reporting on such a case, or testifying at a court-martial, the medical officer will usually be asked to describe the relationship between the state of mind of the accused and the act charged. The determination of criminal responsibility will be based upon the usual four basic questions, and *psychodynamic explanations in themselves are not generally helpful.* The four basic questions are:

(1) Is this a disease of the mind, as distinguished from a character defect?

(2) Did the accused know that he did something wrong?

(3) Was the accused mentally capable of adhering to the right.

(4) Did he have the mental capacity to

form the specific intent or required state of mind?

For the character and behavior disorders, the answer to the second and third questions will be "yes." As for the first and fourth questions, it should be pointed out that while character and behavior disorders are diseases of the "mind" for the purposes of technical medical classification, military law views them as defects of moral character, not mental disorders. For forensic purposes, this (and not the technical medical nomenclature) must be the medical officer's yardstick. *The real question is not one of classification but of effect.* The law is concerned only with whether credible evidence exists which may properly be considered by the triers of the fact in determining whether an accused lacks the mental capacity to entertain a specific intent or have whatever state of mind is required for the offense charged. *It is the evidence presented concerning the disorder and its effect which raises the issue and not the nomenclature used to classify it.*

d. It will be noted that MCM recognizes that character and behavior disorders may cause some "diminution or impairment in ability to adhere to the right." This, however, is very different from stating that the accused is "unable" to adhere to the right. Inability to adhere to the right (because of mental disease) is grounds for finding the accused "not guilty"; but diminution or impairment in ability is only a ground for consideration of partial mental responsibility and in fixing the sentence. The Court of Military Appeals has recognized that character or behavior disorders, if of such nature and severity as to have impaired the accused's ability to entertain a specific intent or a particular and essential mental state, may raise the issue of partial mental responsibility (paragraph 2–7). The mere finding that an accused has a character or behavior disorder is of very little value in determining whether an accused harbored the required state of mind. The nature and severity of the disorder, as it may have actually affected the accused's ability to harbor the required state of mind, must be explained by the medical officer in order to be of value. *There will probably be few cases where a character and behavior disorder will be so severe that it will destroy an accused's deliberative processes.* A character and behavior disorder is likely to be of such gravity only when it is long-standing in nature and when it is on the penumbra of psychosis.

e. At times, the accused may seem to be on the borderline between a severe character and behavior disorder and a psychosis, particularly paranoid, hypomanic, or schozophrenic syndroms. In such cases it is the responsibility of the medical officer to make a clinical diagnosis based on sound psychiatric principles. The distinction may be difficult, but, it is proper to expect the expert examiner to reach a decision. The court is entitled to a clear-cut, expert opinion. The medical officer should not testify that "in a way it is" and "in a way it is not" a mental disorder. In general, a psychosis should not be diagnosed unless there is the same measure of evidence for a psychosis that there would be for a patient who is not being held under charges. Attacks of frenzy and violent temper frequently punctuate the careers of individuals with severe character and behavior disorders, and should not be mistaken for a true psychosis.

3–5. Sex Offenders:

a. Sexual misconduct does not, in itself, constitute a psychiatric category. Individual sex crimes of particularly brutal or repulsive character may arouse so much indignation that the medical officer may experience a tendency to be carried along on a current of panic. However, he has an obligation to introduce a note of sober objectivity into the proceeding by examining the accused, reviewing his history, and making a clinical diagnosis. This clinical diagnosis often will not be that of a primary sex offense. A man

who has had intercourse with animals may turn out to be a severe mental defective, in which case the mental deficiency would be the clinical diagnosis, and his mental responsibility would be appraised as suggested in paragraph 3–2. A person who derives sexual pleasure from inflicting or receiving pain may in certain cases be suffering from a psychoneurosis. Since he knows that such activities are generally considered wrong, he is normally considered mentally responsible.

b. The fact that a crime of violence is colored by a sexual component does not require that the offender be tried on the basis of the sexual component alone. If, for instance, the accused has raped and then killed a child, he could be tried for murder as well as for rape. Nor does the existence of the sexual factor, by itself, exculpate the accused in any way from guilt for the crime of violence. Certain sexual behavior (voyeuristic, exhibitionistic, pedophilic, etc.) is not specifically denounced in the Uniform Code of Military Justice but may be brought to trial under Article 133 or 134.

c. After all cases of mental deficiency, psychosis, and psychoneurosis have been considered, there still will remain a residue of sex offenses which are generally, if somewhat inaccurately, grouped as being the result of "sexual psychopathy." Chief concern will be with those sex offenses in which another person is hurt. This "hurt" may consist of physical violence, or it may be an emotional trauma, such as would be inflicted on a child who had been the victim of sexual advances.

d. Sexual psychopathy has three characteristics:

(1) It is a compulsive act. That is, the offender is fearful of the consequences but has such mounting tension that he feels impelled to go through with the act.

(2) It is a repetitive act. It is only one of a series, part of a general pattern of behavior.

(3) It is a traumatizing act. That is, it inflicts emotional or physical trauma on its victim.

e. Usually, the person who commits such an act is sane and mentally and criminally responsible. If he happens to be psychotic, this should be reported, with the psychosis (not the sexual behavior) as the primary clinical diagnosis.

f. The compulsive nature of the sexual act does not mean that the defendant was unable to adhere to the right. Was the compulsion so great that it overcame his ability to adhere to the right? If the answer is "no," then presumably the accused could have adhered to the right.

g. Ordinarily (except in cases of some very low-grade mental defectives), the accused does know that the act is wrong. This is shown by the fact that the offender seeks to perform his act privately, or under circumstances in which he is not identifiable, or from which he can readily escape undetected. All this bespeaks a knowledge that the act was wrong.

h. Some individuals commit sexual offenses only when drunk. This does not normally affect the criminal accountability of such individuals although it may be considered on the question of partial mental responsibility and affect his sentence.

3–6. The Psychoneurotic. Severe psychoneurosis may constitute one of the "derangements of the mind" within the definition of MCM. The question arises chiefly in connection with dissociative (hysterical) fugues (paragraph 3–3c), compulsive phenomena (paragraph 5), and sexual deviations (paragraph 3–5). A psychoneurotic reaction does not relieve the accused of accountability (except in some states of fugue, panic (paragraph 3–7b(2)(c) below) or in certain compulsive states, but it may be a factor affecting partial mental responsibility (paragraph 2–7) and the sentence. It should be called to the attention of counsel.

3–7. Medicolegal Problems in Combat Psychiatry:

a. The entire spectra of psychiatric entities will be encountered under combat conditions. The only differences might be that with the impact of almost constant threat of injury and sudden death, the symptomatology and onset of disease states of "deviant" activity might appear faster and seem more severe. It must be remembered that individuals respond to stress within their own personality capability and the effect of combat in itself as in any evaluation of stress must be considered by what is expected of the group. The evaluation of psychiatric disease and personality disorder found in combat and among comat personnel is evaluated in the same light as any other psychiatric condition, realizing only that these can, because of the stress, seem more severe and disruptive to the personality. The factor of secondary gain must be ever kept in mind and properly evaluated.

b. Certain diagnostic categories present no special problems in diagnosis or determination of criminal accountability in the combat setting. Individuals with no psychiatric disease, but exhibiting defects of attitude or motivation, are clearly accountable for their criminal acts. The psychiatric evaluation of the character and behavior disorders presents no new or unusual problem in combat. The presence of a psychotic reaction may absolve the individual of criminal accountability for offenses committed while the reaction is present.

(1) No psychiatric disease; normal combat reaction.

(a) Individuals whose reactions to combat are within normal limits must be evaluated as psychiatrically normal. This is true despite the unpleasant nature of many normal combat reactions. It should be borne in mind that normality and abnormality of reactions must be defined in relation to the situation in which the reactions take place. The medical officer who is inexperienced in evaluating the combat reaction may otherwise erroneously judge the manifestation of fear and anxiety by civilian standards, in relation to which the combat normal would be distinctly pathological. The medical officer must understand this principle and possess an adequate base line for its application, if he is to be of value in the assessment of mental responsibility for offenses committed during pressure of combat.

(b) The normal combat reaction is made up of a variable set of marked somatic and psychologic symptoms which arise from physical fatigue and from extreme, repeated, and continued combat fear. Among these normal reactions may be: muscular tension, with headache; transient "freezing"; shaking; tremor; marked perspiration; subjective feelings of warmth or chilliness; loss of appetite; vague abdominal distress; mild diarrhea; urinary frequency or urgency, by day or night; fast or unusual heart action; breathlessness; feeling of tightness in the chest; faintness or giddiness; generalized muscular weakness and lassitude; mounting anticipatory anxiety; "on-guard" reactions to combat noises; sleep difficulties; some diminution in drive, flow of speech, initiative, range of interests and general feeling of well-being; irritability; and resentment.

(c) Most of these symptoms are transient, occur during combat stress and are, accordingly, appropriate to the situation. Pathologic combat reactions involve undue continuance of such reactions into inappropriate (non-combat) situations, or major qualitative alterations in response (inappropriate and unadaptive).

(d) Individuals exhibiting the normal combat reaction should be reported as having no psychiatric disease and assessed as mentally responsible.

(2) Combat-precipitated psychiatric illness (chiefly the anxiety reactions, combat exhaustion and operational fatigue).

(a) *Recognized psychiatric disease entities may have as one of their precipitating factors the severe stress of combat. They must be evaluated from all aspects and not just from the names of the diseases.* The psychiatric disease must so disorganize a personality that he truly would be unable to "distinguish right from wrong and adhere to the right." These conditions in mild to moderate form do not prevent the individual from "recognizing the difference between right and wrong," or from "adhering to the right." Hence, they do not absolve the individual from criminal accountability. Although some men with such a reaction might have merited removal from combat duty through medical channels prior to the offense, the situation is altered by commission of the offense. The medical officer will bear in mind in rendering a medicolegal opinion in such cases that it is his task to assess and report realistically the individual's mental responsibility for his acts. Individuals with severe anxiety reactions in combat circumstances may experience greater than average difficulty in avoiding offenses against the military code. In such cases, the anxiety may properly be reported as rendering "adherence to the right" more than normally difficult. This then may be taken into account by the court in mitigation of the offense. Severe anxiety reactions, with major personality disorganization and clouding of consciousness may render an individual not responsible for acts committed while in the acutely disorganized phase of such reactions. These include the true panics, in which there is temporary, major disorganization of thinking and control, with clouding of consciousness. The actions of the individual are usually wholly unadaptive, and compromise his safety. The most common expression of true panic on the battlefield is the panic run, in which, usually during a shelling, the individual deserts cover and dashes about impulsively, as often toward the enemy as away, exposing himself to flying shell fragments. In other cases of this category, the personality disorganization lasts longer, and the individual concerned remains disoriented, confused, and regressed over a period of days (the "pseudopsychotics" or "three-day schizophrenias"). Retrospective diagnosis of this type of reaction is not difficult if all the facts surrounding the case are at hand and the story can be evaluated for consistency. Most individuals developing true reactions of this type are either killed or wounded as the result of self-exposure to enemy fire or are evacuated medically from their combat assignment as psychiatric cases. In practice few are seen in medicolegal consultations.

(b) *Malingering.* In acute stress situations such as combat there are more problems concerning the diagnosis of malingering. Care must be taken, in the appraisal of individuals' reactions to combat, to consider the possibility of malingering and to evaluate it in relation to the personality structure of the individual.

(3) Severe degrees of mental deficiency may impair an individual's ability to understand what military law and his duty require of him. On the other hand, even if he has such an understanding, his ability to control his actions may be impaired so that he cannot take appropriate steps to secure his relief from intolerable degrees of combat anxiety. However, it is the general military experience that a very large percentage of mentally dull individuals exhibit acceptable self-control in combat. Hence, mental deficiency in combat cases almost never renders the individual not responsible. In this category, as in the neurotic combat reaction, the medical officer should be prepared to estimate for the court what degree of difficulty in excess of the normal the accused may have experienced in adhering to a legally acceptable course under certain given combat circumstances. This may be considered by the court as a possible extenuating circumstance in determining the severity of the

sentence. The medical officer should not overevaluate the numerical results of mental age determinations from intelligence tests which may be administered. Due weight should be given to past performance and other evidences of intellectual capabilities which lie outside the realm of formal psychometric tests.

Chapter 4

EXAMINATION PROCEDURES

NOTE: Psychiatrists many times do not realize that their evaluations may be scrutinized, not only by the court in question but by higher courts, and can influence legal determinations that affect the law. *Good and accurate psychiatric evaluations, simply expressed, can assist in arriving at judicious determinations.*

4–1. Nonprivileged Communications to Medical Officers and Civilian Physicians. Under mili-military law the information acquired by a medical officer or a civilian physician in conversing with a patient or in observing, examining, or attending him may be inquired into by a court-martial. Such communications are not privileged before a court-martial, although the ethics of the medical profession forbid disclosure of them to unauthorized persons.

4–2. Preparation of a Phychiatric Report:

a. When a person accused of an offense is given a psychiatric examination by a board appointed under MCM, or under any regulation or directive, a written report of the examination will be prepared. This report, so far as it relates to the person's criminal accountability, will focus on the questions listed below. Mere affirmative or negative answers to the questions below are inadequate. It is important that they be answered fully and explained where possible. Where a question of intent or other state of mind is involved, the causal relation between accused's mental condition and the required state of mind must be explained. Unless clearly shown inapplicable, each should be commented upon and answered. The report should answer at least these seven questions:

(1) What is the clinical psychiatric diagnosis?

(2) Did the accused know at the time of the offense that the act was wrong?

(3) Was the accused able at the time of the offense to adhere to the right? If not, was this because of a mental defect, disease, or derangement? Was his ability to adhere to the right wholly lacking or only somewhat impaired? (See paragraph 2–3.)

(4) What is his intelligence level? (See paragraph 3–2.)

(5) Was he drinking at the time the act was committed? If so, did it amount to drunkenness and was it voluntary? Is he a chronic alcoholic, a periodic drinker, or a victim of alcoholic psychosis? Was this "pathologic intoxication?" (See paragraph 3–1.)

(6) Does he understand the nature and seriousness of the charges? Is he mentally capable of cooperating in his own defense? (See paragraph 2–6.)

(7) Was the accused able to form the degree of intent, willfulness, premeditation or other mental state called for by the nature of the offense charged? (See paragraph 2–7.)

A medical witness will be prepared, in his testimony, to answer and discuss these questions. It is well also to state in the report the circumstances of the examination, including the procedures used.

b. The report will formally conclude with specific answers to the four questions set out in paragraph 2–1(a). If the examination is made after trial by court-martial, the third question will become: "Did the accused at the time of trial possess sufficient mental capacity to understand the nature of the proceedings against him and intelligently to conduct or cooperate in his defense?"

c. Where a board of more than one officer is submitting a report and there are non-concurrences with the majority the non-concurring members should attach a minority report explaining the minority views. The usual format should be adapted to this purpose.

4–3. Procedures to Determine Mental Responsibility and Capacity by a Board of Medical Officers:

a. Ordinarily, the defense counsel will raise the question of the accused's mental responsibility when this is indicated, and ask for the necessary psychiatric examination. However, the trial counsel and the court-martial also have the duty to guard the accused's rights and will call for evidence in this regard whenever it appears indicated in the interests of justice.

b. A psychiatric examination may be ordered at any time—before, during, or after trial. The convening authority concerned, on request of an investigating officer, trial counsel or defense counsel (or on his own motion) may order the impanelling of a board of medical officers for observation and report, with respect to the sanity of the accused. Under MCM an inquiry by a board of one or more medical officers may be ordered and at least one member of the board should be a psychiatrist. Members of such boards should bear in mind that they have the right to full information as to "the reasons for doubting the sanity of the accused" and a medical officer should not conduct such an examination and issue a report without having first studied the facts surrounding the alleged offense and the personal and medical history of the accused.

c. If it will facilitate examination and disposition, the patient may be hospitalized in order to determine his mental status. Hospitalization should be accompanied only when the nature of examination requires it; when prolonged observation is necessary; when the patient is so sick physically or mentally as to require hospitalization; or when complicated diagnostic procedures are indicated. Whether hospitalized or not, it is essential that unnecessary delays be avoided.

d. It may be necessary to recess or adjourn the trial pending determination of the accused's mental state. The MCM authorizes such recesses or adjournments.

4–4. Suggestions for Psychiatric Examinations:

a. The medical officer conducting the psychiatric examination should remember the questions raised in paragraph 4–2 and keep in mind that the examination will provide the basis of his opinions concerning them. The one item which he might forget to cover may well become a crucial question at the trial.

b. The history and examination should not be stereotyped, and the emphasis will vary from case to case. Thus a man charged with being absent without leave and a man charged with striking his superior officer should be considered from different vantage points.

(1) In the first case, particular attention should be paid to school truancy, running away from home in childhood, length of time on each civilian job, tendency to evade responsibility in civilian life, etc.

(2) In the second case, extensive inquiry should be made in regard to head injuries, encephalitis, methods of parental discipline, attitude toward authority, temper responses, boyhood and adult street fighting, etc.

c. It is essential that the medical officer be furnished with all information pertinent to the case at the time of referral for examination. This should include:

(1) A copy of the charges against the individual.

(2) Information relating to the state of mind, if any, which may be required as proof for the offense or offenses charged. Normally, this information will be furnished by the staff judge advocate or legal officer at

time of referral. For example, a person cannot be convicted of larceny of the property of another unless he intended permanently to deprive such other person of the property. Accordingly, a psychiatric examination of a person accused of larceny should determine among other things whether he was mentally capable of possessing the requisite intent.

(3) Information about the circumstances surrounding the offense (if known).

(4) Statements concerning the individual's past and present behavior, his military efficiency, and any abnormalities of behavior, including his habits as to the use of drugs and alcohol.

(5) Any other pertinent considerations of the law, elements, intent, knowledge, special state of mind, etc., when required for proper evaluation.

d. As far as practicable, the medical officer should obtain all pertinent information about the behavior of the accused before, during, and after the offense.

e. When time permits, statements or records may be obtained from school, former employers, police departments, and other comunity resources as to the patient's behavior outside the service. In cases where such information is deemed vital to a satisfactory understanding of the case, a request will be made by the medical officer to the appropriate authority for the necessary delay.

f. *Before starting his examination, the medical officer conducting the psychiatric examination must advise the accused of the nature of the offense of which he is accused or suspected and make clear to the accused the scope and purposes of the examination. He should also inform the accused that he is neither "for him" nor "against him," and that he may consult with counsel prior to the examination. At the same time the medical officer will advise the accused that he need not say anything and that the medical officer may be called upon to repeat in court, as the basis for his opinion, any statements made to him by the accused.* Sometimes, as an essential part of the psychiatric history, the medical officer may have to consider previous convictions and earlier misconduct. As a witness, the medical officer should refrain from mentioning the accused's previous criminal record or misconduct in support of the diagnosis he is reaching, unless it is necessary to explain the basis of his opinion. The previous criminal record or misconduct ordinarily cannot be considered by the court in adjuding guilt or innocense. The admission of such testimony, even for the purpose of helping establish a psychiatric diagnosis, should be avoided unless required.

g. Normally, there will be no third party witnesses to the examination. Good rapport is best established when the psychiatric examination is conducted with only the medical officer and the patient present.

h. In obtaining a medical history, care should be taken in appropriate cases to obtain careful and detailed histories regarding head injuries, convulsions, amnesia, automatic behavior, periods of unconsciousness, syphilitic infections, and the use of alcohol and drugs. A complete neurologic examination should be performed where indicated. In addition, other specialty examinations should be obtained where warranted. It is advisable to obtain a detailed educational and family history, and the account obtained of the accused's personality makeup should be as complete as practicable. Sexual and marital history should be carefully obtained. A history of previous arrests, even though they resulted in acquittal, may be important. Use of alcohol and drugs is important, including the effect of alcohol and drugs on the behavior of the individual. In appropriate situations, it is well to inquire carefully into the temper responses, including the types of situation which provoke irritability, resentment, and aggression, and into the way in which these manifest themselves. A

full account of the accused's degree of sociability and relationships with others should be obtained.

i. A detailed account from the accused of his military adjustment is of the greatest importance. Particular emphasis should be placed on disciplinary actions, promotion and demotion, reaction to discipline, interest and aptitude in his various assignments, attitudes toward separation from home, oversea service, and combat. An effort should be made to evaluate the patient's motivations. Where appropriate, information should be obtained as to length of time the accused was in combat, whether or not he was wounded, and the course of hospitalization for such wounds. Information should be obtained as to whether the accused has been hospitalized for a psychiatric condition resulting from combat service or otherwise, and his readjustment subsequent to hospitalization.

j. The account of the crime with which the accused is charged should be full. The events immediately preceding the alleged offense should be detailed. His immediate and later reactions are important, including the effect on his sleep, appetite, and other behavior.

k. Psychometric examinations may be helpful to the psychiatrist in his final determinations of the problem before him (see chapter 5). They may also be helpful in furnishing objective evidence of the patient's intelligence level and whether or not there is evidence of intellectual deterioration (paragraph 3–2). Such tests should be carried out whenever indicated.

4–5. Retrospective Interpretation of Mental State:

a. The accused may be charged with an offense months, sometimes years, after the event. The medical officer then may be asked to render an opinion as to the person's mental state at the time of the alleged offense. It is a temptation to dismiss the duty by saying, "I don't know what he was like last year; I didn't examine him then." However, if mental accountability becomes an issue, it is necessary that there be some appraisal of the defendant's mental condition at the time of the offense. The following suggestions may be helpful:

(1) The medical officer is entitled to a full description of the circumstances surrounding the allged offense. If the description is complete enough, it should be possible to visualize the situation. For example, an enlisted man committed an assault and ran away. He was apprehended 6 months later. From the details of the attack, it may be possible to determine whether the assailant was acting impulsively or deliberately, whether he appeared calm or in a frenzy, whether he hurled verbal abuse or acted in moody silence, et cetera. It thus becomes possible to form at least a preliminary estimate of the accused's state of mind.

(2) The offender's own explanation of the event provides further detail. If he denies all recollection of the incident, this is analyzed as suggested in paragraph 3–3 (amnesia). Otherwise, his own explanation gives the medical officer some picture of the accused's state of mind as the subject presents it. To interpret this objectively is part of the everyday work of psychiatry. In eliciting the accused's explanation, the medical officer should keep the privilege against self-incrimination in mind.

(3) If the examination does not take place until long after the offense, it is probably because:

(a) The examination was made after conviction, or,

(b) The accused ran away after commission of the crime and could not be examined until apprehended sometime later.

(c) In situation (a), above, the medical officer is entitled to examine the verbatim transcript of the court-martial proceedings, which will give him a good deal of information about the accused's mental state.

(d) In situation (b), above, the facts of the flight may speak for themselves. They may indicate a well-thought-out plan to escape arrest—which suggests that the accused knew he was doing something wrong. Or the facts of the flight may point to unreasoning panic which, in itself, is another clue to the personality of the accused.

(4) The life history of the patient is carefully studied. Perhaps it is a life punctuated by repetitive or compulsive acts; or a record of frequent outbursts of violence. It may reflect the pattern of the nonaggressive psychopath, or give the picture of previous dissociative or fugue state.

(5) The current clinical mental examination is helpful. If it reveals today a chronic psychosis or shows mental deterioration, it may be a reasonable inference that the psychosis was active a few months ago. This is not an absolute criterion intended to stand by itself, but only one item in a general picture. If today the accused shows the picture of a cyclical psychosis in remission, a reasonable construction of the previous psychiatric history is usually possible. In general, it is most unlikely that a person would have had a substantial mental disorder a few months ago without showing some positive findings at a current mental examination. If he were a compulsive neurotic, an alcoholic, a psychotic, a psychopath or a mental defective last year he will, in all probability, give evidence of having today the same clinical condition, though not necessarily in the same degree or form.

b. At first, the request to appraise a mental condition months or years after the event may seem unreasonable. By careful analysis, however, as suggested above, it may turn out to be less difficult and more profitable than might be expected. This is because most conditions which affect mental accountability are either chronic disorders or periodic ones. It is true that there may have been some evidence, no longer available, which might have caused the medical officer to change his opinion. If asked about this possibility, the medical officer should, of course, acknowledge it. But in the cause of justice, he has a responsibility to make an honest appraisal from whatever evidence is available, filtered through the screen of his own professional acumen. No one will expect him to do more, but in fairness to all concerned, he should not do less.

4–6. Who May Testify:

a. *Nonexpert Testimony.* There is no rule which requires expert testimony on matters of mental accountability to the exclusion of nonexpert testimony. A lay witness may give an opinion concerning the accused's mental condition, provided he has observed the habits, speech, peculiarities, or conduct upon which the opinion is based.

b. *Expert Testimony.* Any physician may testify as an expert psychiatric witness before a court-martial. The extent of a physician's specialized training or experience in psychiatry affects the weight of his testimony rather than his competency as an expert witness. His testimony, to be admissible, must be based upon his personal observation or an examination or study conducted by him or upon a hypothetical state of facts then before the court or to be placed before the court. This insures that the expert opinion or conclusion is strictly personal to the witness and guarantees to the accused the right of cross-examination and confrontation. The primary function of the expert witness is to:

(1) Enlighten the court on the pathology and symptoms of the particular mental disease or disorder from which the accused may be suffering at the time of trial, or from which he may have been suffering at the time of the alleged crime; and,

(2) Explain the effects of such symptoms or such mental disease or disorder on the accused's mental ability:

(a) to realize that the act charged is wrong, or

(b) To control his conduct and adhere to the right.

The usefulness of testimony of this character depends upon the clarity with which it is presented. The reasons for the opinion are more important than the opinion itself. This is true because it is a court composed of laymen who must interpret the evidence and determine mental accountability.

4–7. Effective Presentation of Psychiatric Testmony:

a. A medical officer may impair his usefulness to the court by the use of scientific jargon. Words such as affect, libido, fixation, schizoid, abreaction, and the like are meaningless to the layman. Although they are accepted psychiatric terms, they are not readily understood by the court. The witness should use the approximate lay equivalents, or, if technical terms are unavoidable, should define them. Ordinarily a word like "mood" or "emotions" is better than a word like "affect." For all practical purposes, when a medical officer says that the accused has a "flattened affect" he means that the accused showed little or no emotional response to his predicament, or that his mood seemed inappropriate. The witness should use these latter phrases, and not "flattened affect." Similarly, the word "psychosis" should be defined before use. To many laymen, it means any mental state throughout the range from a simple temper tantrum to a schizophrenic reaction. The distinction between "psychopathy" and "psychosis" should be specifically made. The layman sees the word "psychopathy" as composed of a syllable meaning "mind," another syllable meaning "diseased" and assumes that the word means "insane."

b. An expert witness may use notes jotted down during the examination of the patient to refresh his memory or to establish his past recollection on the witness stand. A carbon copy of his report may be similarly used. If, before he can answer a question, an objection is raised by the other counsel, the witness should remain silent until instructed by the court to answer. The medical officer need not recite a long list of negative tests which he has performed. He must not become emotionally identified with either side; to do so would impair his credibility. He is expected to answer questions honestly without regard to whether the answers hurt or help the accused or the Government. An objective, disinterested and impartial psychiatric examination and an honest, dispassionate, complete and clear presentation of testimony is the standard for medical officers.

4–8. Presentation of Evidence Relating to Sanity:

a. *Inference of Sanity—Burden of Proof.* It may be inferred that all persons are sane and accountable for their behavior. The sanity of an accused need not be decided by the court unless the issue is raised. For example, the fact that an accused's aunt was once a patient in a mental hospital, or that he is said to have been eccentric in early childhood, may not alone raise the issue of sanity. However, evidence presented by persons showing that the accused's bizarre behavior was such as to raise a legitimate doubt of his sanity, or a report from a medical officer or a board of medical officers that the accused has a psychosis, would raise the issue of sanity. These accounts would put the accused's sanity in issue and cast upon the prosecution the burden of proving the accused's sanity by legal and competent evidence beyond a reasonable doubt. In short, a trial starts with the assumption that the accused is sane and accountable. Once an issue of the accused's mental responsibility or capacity is raised, the prosecution must introduce evidence tending to prove that the accused was mentally responsible or has the requisite capacity, as the case may be. If, in the light of all the evidence, including that supplied by the inference of sanity, a reasonable doubt exists as to the mental responsibility of the accused, he must be acquitted. If there is a reasonable doubt as to the mental capacity of the accused, the proceedings cannot continue (paragraph 2–6).

b. *Eliciting of Testimony in a Court-Martial.* The usual method of producing testimony in court is by question and answer. Independent narration is regarded with distrust because it may often introduce irrelevant matters. The party calling the witness, or his counsel, asks questions first. This procedure is called direct examination. The opposing counsel propounds questions next; this procedure being known as cross-examination. Cross-examination is generally limited to the issues raised on direct examination, plus the credibility of the witness. Leading questions may be freely used on cross-examination. Cross-examination is one of the most effective means of testing the truthfulness of witnesses and of revealing errors, inaccuracies of observation or defects of recollection. Every witness should cooperate with the cross-examiner.

c. *Cross-Examination.* Although cross-examination may at times appear pointless and irritating, the witness who loses his patience or grows angry discredits himself and clearly reduces the value of his testimony. Marked evidence of partisanship on the part of an expert witness is justly viewed with disfavor by the court. On the other hand, the witness who is sincere is more likely to impress the court favorably. The medical officer should never hesitate to admit before a court the limitations of his medical knowledge and experience. Such admissions are not interpreted as a display of ignorance but rather as evidence of honesty. The weight of psychiatric testimony is dependent chiefly upon the thoroughness of the inquiry and the examination upon which the opinion is based, the logical way in which the testimony is presented, and the cogency of the reasons given. The examining attorneys have the obligation, when indicated, to make searching inquiries into the methods and techniques employed by the medical officer. An assumption on the part of a medical witness that his conclusions and his techniques are beyond question and beyond the comprehension of the court is to be decried. It is the witness's obligation to make his method and techniques intelligible to the court. When a "yes" or "no" answer is requested, it should be given if such an answer will be a complete response to the question. If a simple "yes" or "no" answer would be misleading, the witness should say so. No court properly denies to any witness the right to qualify his "yes" or "no" answer and he should always be permitted to explain ambiguities in his testimony at some time before he leaves the witness stand.

d. *Hypothetical Questions.* Although the use of the hypothetical question is not the only method of eliciting expert testimony (paragraph 4–8b), medical officers should thoroughly familiarize themselves with its use. Hypothetical questions permit an expert to base conclusions on varying sets of facts, and leaves to the court the task of determining which set of facts is true. In framing a hypothetical question, counsel furnishes the medical officer with a type of case history, based on the evidence in the case, and the witness gives a medical opinion assuming that the hypothesis (the case history) is true. If the facts are in dispute, the witness may be given one hypothesis by counsel for one side and another hypothesis by opposing counsel and will give each answer according to which set of facts is assumed by the question to be true. The medical officer called by one side may be furnished with one set of assumptions, while the medical officer called by the other side may be asked for an opinion on a different hypothesis. It is for the court to decide which set of facts (and, therefore, which psychiatric evaluation) to accept. Incidentally, it is the difference in the hypothetical questions which often accounts for the popular observation that prosecution and defense experts sometimes give different opinions. It is not that either of the experts is biased; it is simply that each bases his opinion on a different hypothesis which has been specified for him by ex-

amining counsel. However, it is not mandatory that an expert opinion be elicited by hypothetical questions. If the expert witness testifies as to his opinion without the data on which the opinion is based having been first specified hypothetically by counsel, the witness may be asked to specify the data on which his opinion is based.

e. *Direct and Circumstantial Evidence.* The mental state of the accused is sometimes revealed by circumstantial evidence. Considerable latitude is allowed in the reception of evidence which may have a relation to the issue of mental responsibility. This rule permits proof of the accused's previous conduct and history if it is relevant and if it is introduced for the purpose of establishing his mental condition. Specific acts alone may not disclose the state of the accused's mind, but may form part of the totality of conduct indicating sanity or insanity. Although mental illness usually is not inherited, a predisposition may be transmitted to descendants. Thus, as part of the accused's mental history, evidence of insanity in the parents or immediate relatives of the accused may be admitted on the issue of sanity if there is independent evidence tending to show insanity in the accused.

f. *Limitations on Expert's Testimony—Legal Conclusions.* An expert medical witness is not qualified to express an opinion on questions of law. He should not, for example, describe the accused as "legally sane" or "legally insane." He may, however, express an opinion in the terms of the standard, that is, he may express an opinion as to whether an accused has the mental capacity to distinguish right from wrong, to adhere to the right, or to possess a special mental state. His opinion should be as positive in form as his convictions will permit. If phrased in terms indicating uncertainty or conjecture, it will be of little assistance to the court. A court will appreciate a witness's understanding that it has the responsibility of deciding the issue.

Chapter 5

CLINICAL PSYCHOLOGIST

5–1. The Role of the Clinical Psychologist in Military Justice:

a. Psychology is concerned with the scientific study of man's behavior, both normal and abnormal. The psychologist has been trained to evaluate personality, identify emotional states, and establish intellectual levels by means of standardized psychological techniques which have acceptable levels of validity and reliability.

b. As is true also of medical tests, the value of psychodiagnostic techniques depends on:

(1) The aptness of the selection of a given test to the problem at hand, and

(2) The acuity and level of training of the psychologist who interprets the test responses.

Much of the criticism that is occasionally leveled at psychological test methods is precluded if these two factors are sufficiently taken into account. Actually, whenever two persons meet for the first time, some type of an evaluation goes on. Often this evaluation leads to misleading conclusions because of prejudices, a lack of knowledge of what to look for, and lack of time for considering all pertinent factors involved. Psychological testing consists of nothing more than an attempt to base such judgments on scientifically selected samples of behavior which, according to norms gathered from large groups of differing populations, are capable of discriminating levels between various types of individuals. To qualify as a valid psychological instrument, these pre-tested samples are elicited under standardized conditions of administration. Since responses to these samples or "tests" are objectively compared to the typical responses of many different kinds of clinical groups, the psychologist is not confined to his own personal experience or judgment, but can utilize all the published diagnostic data accumulated over a period of many years by many other investigators.

c. The clinical psychologist often serves as a consultant to the psychiatrist, neurologist, and other medical specialists in the formulation of a diagnosis, the establishment of competency, and in the identification of mental defect, disease or derangement. It has been held legally acceptable for a psychiatrist, in arriving at his diagnosis of a person, to use findings and opinions of a clinical psychologist pertaining to that person. It has also been held that clinical psychologists may qualify as expert witnesses competent to render expert opinions based on their findings as to the presence or absence of mental disease. Whether a particular clinical psychologist is so qualified depends upon the nature and extent of his knowledge, training, and experience. This determination must be made in each case, after hearing, by the trial court.

d. Typical contributions that a well-qualified clinical psychologist can make:

(1) Describe level of intellectual functioning and identify mental deficiency.

(2) Estimate the amount of loss of efficiency of mental processes due to organic brain disease, toxicity, or other organic factors.

(3) Help identify the presence of organic brain disease by means of psychological techniques and describe the intellectual areas likely to be affected.

(4) Render a description of the personality structure of a tested individual giving strong and weak points, describing the na-

ture of the emotional defenses habitually used by the testee.

(5) Help in the identification of psychosis, neurosis, or character disorder; and evaluate a patient in terms of these and other nosological categories by means of psychological test responses.

(6) Identify the kinds and strength of the emotional controls an individual has at his disposal.

(7) Evaluate whether or not a person is malingering in the test situation or whether he attempts to give a distorted image of himself.

(8) Elicit signs of psychosexual conflicts and help in the identification of sexual abnormalities.

(9) Estimate the kinds and amounts of anxiety, depression, suicidal tendencies, hostility and aggressiveness which are present, and identify the manner in which the patient is prone to express, escape, or avoid these tendencies.

(10) Give an estimate of the reliability of a person's statements in terms of tendencies to distort reality concepts on the psychological examination.

(11) Assist in making a prognosis of an individual's ability to adjust satisfactorily in society and estimate the kinds and amount of psycho-therapy that may be required before such an adjustment can take place.

e. Among the tests that have proved useful in making determinations in factors (1) through (11), above, in cases of courts-martial, are the following:

1. Wechsler Adult Intelligence Scale (WAIS).
2. Stanford-Binet Intelligence Scale (SBIS).
3. Rorschach Test of Personality Diagnosis (R).
4. Kahn Test of Symbol Arrangement (KTSA).
5. Thematic Apperception Test (TAT). (There are several different kinds.)
6. Sentence Completion Test (SC).
7. Draw-A-Person (DAP).
8. Minnesota Multiphasic Personality Inventory (MMPI).
9. Weigl-Goldstein-Scheerer Test (WGS).

f. There are other tests and techniques available to the clinical psychologist that may supplement or replace any of the ones cited above. Rarely will any single test suffice to give an adequate picture of the personality and a battery consisting of three or more tests is usually required to establish confidence in a psychological evaluation. An exception may be when the only question involved pertains to intellectual capacity as measured by intelligence tests. Confidence in a diagnositic impression is established when personality traits elicited on a test of one psychological dimension are supported by corroborating signs on tests on another dimension, using different kinds of stimulus material. It is the duty and prerogative of the examining psychologist to select the tests and techniques he feels are most adequate in obtaining the information required.

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NG: State AG (3)
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For explanation of abbreviations used, see AR 320–50.

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